What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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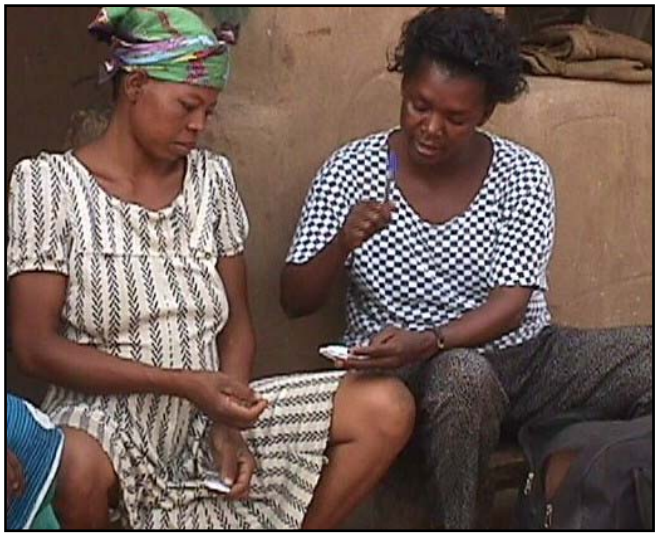
A GOOD IDEA THAT FAILS

DRUG EXEMPTIONS IN THE CONTEXT OF DOORSTEP CARE

The Navrongo Experiment trains Community Health Officers (CHO) to provide as wide a range of services as possible. Since they are certified paramedics of the Ghana Health Service they offer a more extensive range of drugs than the volunteer Yezura Zenna's (YZ) can provide. The main difference is that, unlike YZ who are not allowed to handle or dispense antibiotics, CHO dispense antibiotics and may give injections when the need arises. In addition to all the drugs that YZ handle, CHO, at any point in time, have the following drugs in stock:

- Folic acid for nutritional inadequacies;
- Mebendazole for intestinal parasites;
- Salbutamol for asthma attacks;
- Penicillin V, Co-trimoxazole, Amoxycillin and Metronidazole as antibiotics/anti-infectives and;
- Eye ointment/drops for eye infections.

CHO provide the full complement of family planning services: Depo Provera, oral contraceptive pills, foaming tablets, and condoms as well as counseling, treatment of minor side effects, and referral services.



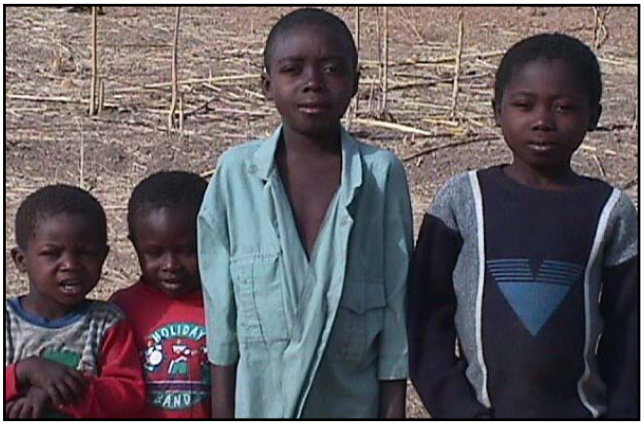
A CHO has more exemption cases than she has free drugs to offer

In 1999, the Navrongo Community Health and Family Planning Project (CHFP) implemented the Ministry of Health "Exemptions Policy" which entitled all children under five years of age, pregnant women, and the elderly, that is, people of 70 years and above, to free drugs. Under this policy, available stocks of drugs are distributed with each prescription generating "Exemption vouchers". These in turn are accumulated for the Regional Health Administration to release funds for the purchase of new supplies to replenish stocks through the regional pharmacy. But, since CHO are so active in reaching exemption cases through doorstep services, the pace of service delivery quickly outstripped the resources of the Regional Health Administration. This led to severe lapses in the flow of drugs, and basic CHFP services were impaired. Some nurses even abandoned community-based care altogether. Without drugs for treatment, the entire programme lost its rationale.

Responding to exemption failures

The CHFP responded to the Exemptions Policy failure by developing community participation in cost recovery. Simply imposing charges would have generated misunderstanding. However, community dialogue about the problem led to fees for drugs dispensed at the doorstep and the CHC. After dialogue with each community, as with YZ, the community determines the prices at which drugs handled by CHO are sold. Agreements are based on the notion of reciprocity. The Ghana Health Service supports CHO residency in the community and provides fuel for their motorbikes. The communities share in the costs of the programme by financing the pharmaceutical component of care. Once services are launched, drugs are stored in a lockable box and kept by the CHO who collects them from the District Health Management Team and the CHFP. She takes a small quantity of drugs at a time when she goes on compound-to-compound visits. As she treats patients and prescribes drugs the patients "cash and carry". When her drugs are running out or when she has money from an old consignment of drugs, she sends the money and renders

accounts directly to the DHMT/CHFP and collects new drugs. With regard to family planning, CHO collect family planning devices from the District Public Health Nurse (DPHN), offer them to clients and render accounts back to her. When a DPHN is proceeding on leave and another has to relieve her, it is the DHMT, the sub-district or the CHFP that supervises the handing over of drugs to the relieving DPHN. Once a month an inventory of the drugs on hold by the CHO is checked to make sure that they are accounted for.

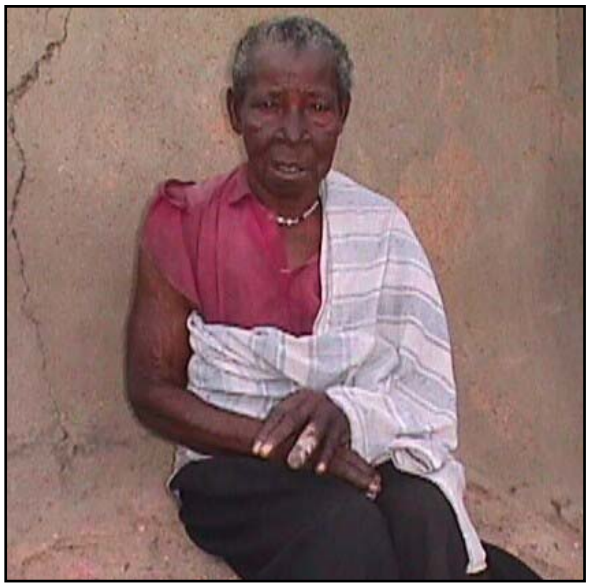


Children waiting for their nurse to come, with or without free drugs.

CHO face unique problems in the course of their duties with respect to the management of drugs. For example, CHO often come into contact with patients who cannot afford to pay for a simple malaria course. Some pay for drugs by installments and others plead to take the drugs on credit and pay by the next market day by which time they would have sold a fowl or two or some farm produce to raise the money. Sometimes CHO have to glean from their own meager resources to pay for drugs for one patient or another. Miraculously, the nurses not only get by but also actually succeed in maintaining excellent rapport with the community members. The nurse's main headache is how to balance the issue of sustainability with the exemptions policy. Some people in the community continue to argue that drugs should be given to them for free. Even when they could pay for drugs with relative ease they sometimes refuse to do so.

When the CHO, like the YZ, is found to owe drug money, she is made to pay before new drugs are issued to her. In most cases the balances that are due to be paid are in the form of drugs held by YZ/YN or CHO, but there are communities that fall into serious debt as they do not have money or drugs. All the same, it must be clearly stated that no CHO or community owes drugs money to the point of being unable to qualify for new supplies, and that is the major strength of the system.

Overall, the management of the drugs has been successful. The average rate of recovery on drugs taken by CHO is 89%, as compared to YN/YZ, which is 83%. This is considered to be a marvelous achievement by the CHO. The major challenge to the Ministry of Health's laudable exemptions policy has been CHO efficiency—they are able to reach more exemption cases than they have free drugs to offer them!



Still counting the cost of free drugs.

What works

Community-based management of drugs can be effectively carried out when the community is involved in such activities with some support. The effective management of drugs requires accountability with regular checks and supervision. With the availability of drugs and family planning devices in the community, treatment of minor ailments and family planning services are received at their doorstep. The Exemptions Policy is a good idea when patients bear the cost of travel to distant clinics. For this reason, the policy is continued at Level B sub-district clinics and at Level C—the Nankana District hospital. But when the health service system finances care at Level A—the doorstep or community clinics—the policy is a good idea that fails. Dramatic increases in the volume of health care cannot be sustained with existing resources.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.